



A Guide to Helping Illinois Medicare Beneficiaries Under Age 65 with Disabilities Make Informed Coverage Choices

Medicare is a federal health insurance program for older adults age 65+ and for people with disabilities under age 65. Navigating Medicare enrollment options can be complex, but particularly so for people with disabilities since enrollment and eligibility options may vary than those for older adults. As a result, professionals who counsel Medicare beneficiaries with disabilities should be aware of how coverage options vary.

This guide is designed to help professionals understand the different coverage options available to Medicare beneficiaries with disabilities and help them select coverage that best meets their needs. Please note: This guide does not cover enrollment or coverage options for individuals with Medicare due to Amyotrophic Lateral Sclerosis (ALS) or End-Stage Renal Disease (ESRD), or for people with disabilities who have Medicare and return to work.

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Introduction

Original Medicare does not pay 100% of medical costs and beneficiaries are responsible for deductible and cost sharing amounts. To help manage these costs, many beneficiaries apply for benefit assistance programs or enroll in additional coverage. Options include:

- Medicaid (benefit assistance program if eligible)
- Medicare Savings Programs (MSPs), including QMB, SLMB, and QI, which can pay all or some Part A and Part B (if eligible)
- Medicare Supplement (Medigap) policy

- Medicare Part D
- Medicare Advantage plan

The coverage options available to a beneficiary depend on multiple factors, including eligibility, health and drug needs, enrollment timelines, and preference.

When helping beneficiaries with disabilities review coverage options, it's best to start by screening them for benefit assistance programs, such as Medicaid and the Qualified Medicare Beneficiary Medicare Savings program (MSP). If eligible, these programs cover most or all Part A and Part B out-of-pocket costs, so enrolling in a Medicare Advantage or Medicare Supplement plan may not be necessary.

Beneficiaries with disabilities who do not qualify for benefit assistance programs still have options to help manage out-of-pocket cost that include Medicare Supplement or Medicare Advantage plans.

Original Medicare

Original Medicare is a federal health insurance program run and administered by the Centers for Medicare and Medicaid Services (CMS). It consists of Part A (hospital) and Part B (medical) benefits and covers inpatient care and outpatient medical care like doctors' visits and preventive care.

Coverage: Medicare Part A helps cover inpatient hospital and skilled nursing facility care, hospice services, and some home health care. Medicare Part B covers medical services including doctor visits, preventive care, diagnostic tests, durable medical equipment, and outpatient medical services.

Eligibility: To qualify for premium-free Medicare Part A, an individual must be age 65+ or under age 65 with a qualifying disability, a U.S. citizen or legal permanent residentⁱ, and have at least 40 Social Security covered work credits.

The number of work quarters required for individuals with disabilities depends on the individual's age at the time their disability begins. Individuals under age 65 may qualify for Medicare Part A and Part B if the Social Security Administration (SSA) determines they are disabled and they have received Social Security Disability Insurance (SSDI) benefits for 24 months.

Costs: Medicare Part A is usually premium-free and Medicare Part B has a monthly premium of \$202.90 in 2026. Original Medicare, however, does not cover 100% of hospital and medical costs and beneficiaries are responsible for paying [deductibles, co-pay, and co-insurance amounts](#) for Part A and Part B services. In addition, Original Medicare does not have an annual out-of-pocket limit, which means a beneficiary's health care costs can add up quickly and as a result, beneficiaries often consider enrolling in additional coverage to help manage and limit out-of-pocket expenses.

Enrollment: Individuals under 65 and on Medicare due to a disability are automatically enrolled into Original Medicare Part A and Part B after receiving Social Security Disability Insurance (SSDI) benefits for 24 months, also referred to as the 24-month

waiting period. Medicare start dates may vary depending on an individual's disability determination process and retroactive (backpay) of benefits. Beneficiaries receive a Medicare welcome packet and Medicare card three months before their Part A and Part B coverage begins. This is also when their Medicare Initial Enrollment Period (IEP) begins. The IEP is a 7-month period that begins three months before a beneficiary's 25th month of receiving SSDI, month of, and up to 3-months after (also called 3-1-3 rule). During this time, beneficiaries should review their options and make a choice as to how they would like to receive their Medicare benefits and enroll in any additional coverage that best meets their needs.

Some beneficiaries under 65 with disabilities may be able to delay enrolling in Part B if they have creditable health coverage through an employer group plan based on their own, a spouse's, or a family member's current employment. It's important that beneficiaries who choose to delay enrolling in Part B due to employer-based coverage confirm enrollment decisions with both their health plan's benefits administrator and SSA to avoid any enrollment delays and late enrollment penalties. Later, a special enrollment period (SEP) will be available for those individuals to enroll in Medicare while covered by a group health plan, or when current employment or their group health plan ends - whichever happens first.

Additional [SEPs](#) may be available for exceptional conditions that include individuals impacted by an emergency or natural disaster, misrepresentation by an employer or group health plan, termination of Medicaid eligibility, formerly incarcerated individuals, and other exceptional circumstances beyond a beneficiary's control.

Most beneficiaries under 65 are automatically enrolled in Part A and Part B, once eligible for Medicare. However, beneficiaries under 65 who choose to decline Part B and do not have [creditable employer-based coverage](#) or otherwise qualify for a SEP due to an exceptional condition must use the Medicare General Enrollment Period (GEP) if they decide to enroll in Part B later. The Medicare GEP takes place annually January 1 – March 31 and late enrollment penalties usually apply. Questions regarding eligibility and enrollment are handled by the Social Security Administration (SSA).

Medicare Part D

The Medicare Part D benefit provides outpatient prescription drug coverage and is available through private insurance companies that contract with Medicare.

Coverage: Beneficiaries can choose to receive Part D coverage either through a stand-alone Part D plan or a Medicare Advantage plan in one of two ways:

- Stand-alone prescription drug plans (called a PDP) that cover only prescription drugs and works with Original Medicare Part A and Part B **or**
- Medicare Advantage (MA) plans, which are Medicare health plans that include Part A, Part B, and usually Part D benefits all through one plan. (MA is an alternative to Original Medicare)

Each Part D and MA plan creates its own list of covered prescription drugs (called a formulary) and pharmacy network. Even if a drug is on a plan's formulary, it's important to check whether the drug has restrictions such as prior authorization, step therapy, or quantity limits.

Eligibility: If enrolling in Part D coverage through a PDP, a beneficiary may be enrolled in either Part A, Part B, or both. However, beneficiaries who choose to enroll in an MA plan must be enrolled in both Part A and Part B since benefits are bundled though one health plan.

Costs: Part D plans usually have a monthly premium, although some plans in Illinois may offer a \$0 premium. In addition to any monthly Part D plan premium, some plans have an annual drug deductible, which means the beneficiary must first pay the deductible amount before the plan starts covering a portion of drug costs. Once any deductible amount is met, beneficiaries pay a co-pay or coinsurance amount for each covered formulary drug, depending on the type of drug. All Medicare Part D plans are required to have an out-of-pocket limit for covered drugs. Once the limit is met, the beneficiary pays nothing for covered drugs for the remainder of the calendar year.

Beneficiaries who do not enroll in Medicare Part D when first eligible and do not have [creditable drug coverage](#), usually have to pay a late enrollment penalty if they enroll at a later time. The penalty is 1% extra premium (based on the national base premium) for each month the beneficiary was eligible to enroll in Part D but did not. The Part D penalty is not capped, meaning the longer a beneficiary goes without Part D or creditable drug coverage, the more expensive their penalty will be IF they enroll at a later time.

Enrollment: Beneficiaries can enroll in Part D during the following enrollment periods:

- Initial Enrollment Period (IEP) is a 7-month period that begins 3 months before a beneficiary's 25th month of receiving SSDI, month of, and up to 3-months after (3-1-3 rule).
- Medicare Annual Open Enrollment Period (OEP) is an annual period from October 15 – December 7 that allows beneficiaries to enroll, disenroll or switch Medicare Part D and Medicare Advantage plans. Any enrollment made during this period takes effect January 1st of the next calendar year. Since Part D plans can change coverage and costs from one year to the next, it's important for beneficiaries to compare their plan options every year during the annual Medicare OEP and enroll in a plan that works for them.
- Special Enrollment Periods (SEPs) are opportunities to switch or enroll in a Part D or MA plan outside of an IEP or the annual OEP. SEPs are available for different situations, and each has its own criteria and time frame. Some commonly used SEPs include moving to a new geographic area, qualifying for the Extra Help program, or losing other creditable drug coverage. Click [here](#) for a complete list of Medicare Part D SEPs.

The Extra Help Program - Help Paying for Part D

Some beneficiaries with limited incomes may be eligible for the Extra Help Program to help pay for Part D plan costs. The Extra Help Program, also referred to as the Low-income Subsidy or LIS, is a federal assistance program that helps Medicare beneficiaries pay for their Part D plan premium and drug costs. If eligible, Extra Help can be used with a Medicare Part D stand-alone plan or a Medicare Advantage plan that includes drug coverage.

To qualify, Medicare beneficiaries must meet income and asset limits and apply through the Social Security Administration online or by calling SSA and requesting a paper application. Some beneficiaries that receive Medicaid, Supplemental Security Income (SSI), or Medicare Savings Program (MSP) benefits will [automatically receive](#) Extra Help and don't need to apply. To learn more about Extra Help benefits and how to apply visit <https://www.medicare.gov/basics/costs/help/drug-costs>.

Medicaid

Medicaid is a health insurance program for people with limited incomes and funded by the federal and state governments. In Illinois, Medicare beneficiaries with disabilities under age 65 qualify for the AABD Medicaid category (Aid to the Aged, Blind and Disabled), or the Family Care category if they are caring for their children or relatives age 18 or younger. (Note, some adults with disabilities may qualify for ACA Medicaid, but only if they are not eligible for Medicare.) Beneficiaries can apply at any time and must be a U.S. citizen or qualified non-citizen, live in Illinois, and meet [income and asset criteria](#).

Coverage: Individuals who qualify for Medicare and Medicaid are referred to as “dual-eligibles.” Dual eligibles have most of their hospital and medical care covered by Medicare and Medicaid. Medicaid also covers services not covered by Original Medicare, including dental, vision, hearing, and long-term care services and supports.

Dual-eligible beneficiaries receive coverage for prescription drugs through Medicare Part D and not Medicaid. Once a beneficiary becomes a dual-eligible, they must enroll in a Part D plan for drug coverage or CMS will automatically enroll them in a stand-alone Part D plan. As a reminder, dual-eligible beneficiaries automatically qualify for the Extra Help program to help pay for Part D costs.

Dual-eligible beneficiaries can choose how they want to receive their Medicare and Medicaid benefits. (Fee-for-service Medicaid means that Medicaid and Medicare are billed separately for services.) Options include:

- Fee-for-service Medicaid, Original Medicare Part A and Part B, a stand-alone Part D plan for prescription drug coverage **OR**
- Fee-for-service Medicaid and a Medicare Advantage plan that includes Part D coverage **OR**
- A Medicare dual-eligible special needs plan ([D-SNP](#)), a type of Medicare Advantage plan newly introduced to Illinois in 2026 and only available to

beneficiaries with Medicare and Medicaid. Dual-eligibles can enroll, disenroll, or switch D-SNPs at any time.

Eligibility: To qualify for AABD Medicaid a beneficiary must be 65+, blind, or disabled. An individual's household income must be at or less than 100% of the federal poverty limit and assets less than \$17,500. If their income and/or assets exceed the AABD limits, they may be able to Spenddown for AABD eligibility. To learn more about Medicaid Spenddown click [here](#).

Costs: Dual-eligible beneficiaries have very low to no out-of-pocket cost sharing for services covered by Medicare and Medicaid. It's important to note that AABD Medicaid does not cover a beneficiary's Medicare Part B premium and instead is covered through the Medicare Savings Program (MSP). As explained below, MSPs help pay for at least the monthly Medicare B premiums and at times, Part A and B cost sharing. Many dual-eligible beneficiaries also qualify for an MSP since their income and assets are limited.

To help manage Medicare Part D costs, dual eligible beneficiaries automatically qualify for the [Extra Help Program](#).

Enrollment: The Illinois Department of Human Services (DHS) processes Medicaid applications and the Illinois Department of Healthcare Family Services (HFS) administers and manages Medicaid benefits. Individuals can apply for Medicaid through DHS at any time of the year using any of the following methods:

- Online using the Illinois Application for Benefit Eligibility (ABE) system (recommended)
- Submitting a [paper application](#) by mail or in person to a [local Illinois DHS office](#)
- Over the phone by calling (800) 843-6154

Medicaid applications for disability-related cases are typically processed within 60 days. If an application is taking 60 days or longer to be processed, beneficiaries can request a temporary medical card (also referred to as a T card). To learn more about requesting a temporary medical card, click [here](#).

Medicare Savings Programs

Medicare Savings Programs (MSP) are programs that help Medicare beneficiaries who have limited incomes and assets pay for Medicare Part A and Part B premiums and/or cost sharing amounts. MSPs are administered through Illinois Medicaid.

Coverage: There are three types of MSPs:

- Qualified Medicare Beneficiary (QMB) pays for the Medicare Part A and Part B monthly premiums, deductibles, and co-insurance amounts
- Specified Low-income Medicare Beneficiary (SLMB) pays the monthly Part B premium
- Qualified Individual (QI) pays the monthly Part B premium

If an individual has a Medicare Part A and/or Part B late enrollment penalty, qualifying for any MSP eliminates the penalty. Additionally, beneficiaries who qualify for any one of the three MSPs also automatically qualify for the Extra Help Program which helps pay for Part D plan costs.

The Qualified Disabled Working Individual (QDWI) is an MSP for some people with disabilities under the age of 65 who lost their Social Security Disability benefits and Medicare premium-free Part A because they returned to work. QDWI will only assist these individuals to pay for the Part A premium. To qualify, an individual cannot be eligible for Medicaid, must meet citizenship and residency requirements, have monthly income at or below 200% of the federal poverty level, and assets of no more than \$4,000 if single or \$6,000 if married. To learn more about QDWI, [click here](#).

Eligibility: Eligibility and the type of MSP a beneficiary qualifies for is determined by Medicaid and based on a beneficiary's income and assets. To qualify for any MSP, a beneficiary must be enrolled in Medicare Part A and eligibility is determined by the beneficiary's income and assets. The current Illinois MSP income and asset limits can be found [here](#).

Costs: All three MSPs cover the monthly Part B premium for eligible beneficiaries, however only QMB covers Medicare Part A and Part B cost sharing amounts. It's important to note that beneficiaries who qualify for the QMB program are not liable for any Medicare cost sharing amounts. Medicare physicians and providers are legally [prohibited](#) from billing QMB-eligible beneficiaries any Medicare deductible, co-insurance, or co-payment amounts, even if the provider does not accept Medicaid. As a result, beneficiaries who qualify for the QMB program in most cases do not need to enroll in other supplemental coverage such as a Medigap or regular Medicare Advantage plan since they are not liable for Medicare cost sharing.

SLMB and QI, however, only cover the Part B premiums so beneficiaries should consider enrolling in additional coverage to help pay for Medicare Part A and Part B deductible and cost sharing.

Enrollment: The Illinois Department of Human Services (DHS) processes applications and determines which MSP a beneficiary qualifies for. Beneficiaries can apply for MSP at any time of the year through the Illinois Medicaid ABE (Application for Benefits Eligibility) website at <https://abe.illinois.gov> or submit a [paper application](#) to their [local DHS office](#) by mail or in person. It is recommended that applications are submitted online since they are time stamped and processed faster. Once an MSP application is received with all the necessary information, Illinois DHS has 45 days to process it. Applications that are not processed in a timely manner can be referred to the [Avisery MSP Referral Pathway](#) for assistance.

Medicare Supplement (Medigap)

Medicare Supplement plans, also referred to as Medigap, are health insurance policies sold by private insurance companies to supplement Original Medicare.

Coverage: Medigap plans fill in the gaps not covered by Medicare and can only be used with Original Medicare Part A and Part B. These plans help pay some of the costs not covered by Medicare Part A and Part B such as deductibles, copayments, and coinsurance amounts. Since Medigap plans supplement Original Medicare, these plans pay after Medicare and only cover services Medicare covers. Medigap plans can generally be used with any doctor or provider in the U.S. that accepts Medicare. In addition, they do not include prescription drug coverage and beneficiaries who choose to buy a Medigap policy must enroll in a separate stand-alone Part D plan if they want drug coverage.

In Illinois, Medigap plans are standardized and labeled by letters (plans A-N). All plans cover the same core benefits with different plan letters covering additional benefits. Since plans are standardized, plans with the same letter provide the same benefits regardless of which insurance company offers them (i.e. a plan G with Company Red covers the exact same benefits as Company Green). What varies between companies are the monthly premiums and customer service.

Eligibility: Beneficiaries must be enrolled in Medicare Part A and Part B to purchase a Medigap policy. The best time to purchase a Medigap plan is when a beneficiary has guaranteed issue rights. [Guaranteed issue rights](#) means that beneficiaries cannot be denied coverage or be made to wait for coverage to begin, but Medicare beneficiaries only receive these rights in specific circumstances.

Costs: Medigap monthly premiums depend on the type of plan a beneficiary selects and will be in addition to the monthly Part B premium. Premiums are based on age, gender, and where the beneficiary lives. It's important to note that even if individuals with disabilities under the age of 65 receive guarantee issue rights, Medigap premiums are significantly higher than for the 65+ population but cannot exceed the highest premium rate filed with the Illinois Department of Insurance.

In addition to monthly premiums, a beneficiary may also be responsible for some Medicare out-of-pocket costs, depending on the type of Medigap plan a beneficiary chooses. While Medigap plans cover Medicare cost sharing amounts, not all plans cover costs in full. Beneficiaries interested in purchasing a Medigap policy can contact the company directly for details or a premium quote.

Enrollment: Federal law does not require Medigap companies to sell policies to Medicare beneficiaries under 65 with disabilities. However, Illinois law requires companies to offer Medigap coverage with guaranteed issue to beneficiaries with disabilities under 65 during specific times.

The first opportunity is during a beneficiary's Medigap Open Enrollment Period (OEP) which is a six-month period that begins when a beneficiary's Medicare Part B coverage starts. For beneficiaries with disabilities, this often happens at the same time as the beneficiary's Medicare Initial Enrollment Period (when they are first eligible and auto enrolled in Medicare after receiving SSDI benefits for 24 months). During this time, beneficiaries under age 65 with disabilities in Illinois can purchase a Medigap policy

from any company and cannot be denied coverage due to pre-existing health conditions. Once the six-month Medigap OEP period ends, companies are no longer required to sell beneficiaries under 65 a policy and can deny coverage due to a beneficiary's pre-existing health conditions. The Medigap OEP is usually the best time for a beneficiary with a disability to purchase a plan since they can buy a policy from any company and cannot be denied coverage. The Medigap OEP for individuals with disabilities who are retroactively approved for Medicare begins on the date they receive notice of their retroactive eligibility.

If a beneficiary under 65 did not purchase a Medigap when first enrolled in Part B during their Medigap OEP, there is a limited time special enrollment period (SEP) October 15 through December 7 of each year to buy a plan. This SEP allows beneficiaries with disabilities under age 65 to purchase a Medigap with guaranteed issue rights from October 15 through December 7 regardless of their health history. Note that in Illinois only one company, Blue Cross Blue Shield of Illinois, will sell beneficiaries under 65 a policy during this time.

Outside of a beneficiary's Medigap OEP and the limited-time SEP offered by Blue Cross Blue Shield of Illinois, companies may use medical underwriting or refuse to sell a Medigap policy to a beneficiary under age 65. When a beneficiary with a disability turns 65, they receive a new six-month Medigap OEP based on age rather than disability which may result in premium savings.

The Illinois Senior Health Insurance Program (SHIP) has created a useful guide called "Medicare Choices" that includes detailed information about how Medigap works for beneficiaries with disabilities under age 65, and 65 or older:

<https://ilaging.illinois.gov/ship.html>.

Medicare Advantage

It's important to note that although Medigap policies can help pay some or most of Part A and Part B deductibles and co-insurance amounts, the monthly premiums can be costly and may not be affordable for beneficiaries with limited incomes. As a result, some beneficiaries who do not qualify for the QMB program and cannot afford a Medigap policy, may consider enrolling in a Medicare Advantage plan to help manage out-of-pocket costs.

Coverage: Medicare Advantage (MA) is an alternative to Original Medicare and also referred to as Part C. MA plans are private companies that contract with Medicare to provide beneficiaries their Medicare benefits. MA plans typically offer Part A, Part B, and usually Part D prescription benefits bundled through one health plan. Many MA plans also include extra benefits that are not covered by Original Medicare, such as dental, vision, or hearing.

There are different types of MA plans a beneficiary can select, each with its own set of rules (for ex. HMO, PPO). MA plans usually require their members to use a network of providers for care to be covered or for the member to pay less, depending on the type of

plan selected. In addition, many MA plans use prior authorization, which requires the plan's approval before a service is covered.

Beneficiaries who choose to receive their Medicare benefits through an MA plan should carefully review the plan's rules and ensure they understand how the plan works before enrolling. This review should include making sure their doctors and providers are in the plan's network and that their drugs are on the plan's formulary, along with reviewing costs (premiums and cost sharing amounts).

Eligibility: To be eligible for an MA plan a beneficiary must be enrolled in Medicare Part A and Part B and live in the plan's service area.

Costs: MA plans may charge a monthly plan premium, but some plans offer a \$0 monthly premium. It's important to note that even if a plan has a \$0 monthly premium, beneficiaries must continue to pay the monthly Part B premium. In addition, MA enrollees are generally charged a co-pay or coinsurance amount each time they use a service.

All MA plans are required to set a maximum annual pocket limit (MOOP) limit for covered services. Once a beneficiary reaches the plan's MOOP limit, the plan covers all Part A and Part B costs for the remainder of the calendar year. Please note that prescription drugs are **not** included in the MOOP limit (Part D has its own out-of-pocket limit).

The Medicare Plan Finder tool available on www.Medicare.gov is the easiest way to compare all available MA plan options. It allows beneficiaries and professionals to search for plans and view details such as premiums, cost sharing, covered benefits, provider networks, and drug formularies.

Enrollment: Beneficiaries can enroll in an MA plan during the following enrollment periods:

- The Initial Enrollment Period (IEP) is a 7-month period that begins 3 months before a beneficiary's 25th month of receiving SSDI, month of, and up to 3-months after (3-1-3 rule).
- The Medicare Annual Open Enrollment Period is an annual period from October 15 – December 7 that allows beneficiaries to enroll, disenroll or switch Medicare Advantage and stand-alone Part D plans. Any enrollment made during this time is effective January 1st of the next calendar year. Since Part D plans can change coverage and costs from one year to the next, it's important for beneficiaries to compare their plan options every year during the annual Medicare OEP and enroll in a plan that meets their needs.
- The Medicare Advantage Open Enrollment Period (MA OEP) takes place January 1 – March 31 of each year. The MA OEP allows beneficiaries in Medicare Advantage plans to make a one-time change to another MA plan or return to Original Medicare Part A and Part B. Beneficiaries who return to Original Medicare also receive an SEP to enroll in a stand-alone Part D plan.

- Special Enrollment Periods (SEPs) are opportunities to switch or enroll in an MA and Part D plan outside of established enrollment periods. SEPs are available for different situations, and each has its own criteria and time frame. Some commonly used SEPs include moving to a new geographic area, qualifying for the Extra Help program, or losing other creditable drug coverage. Click [here](#) for a complete list of SEPs.

Where to go for help

Beneficiaries who need help reviewing their Medicare options to determine which type of coverage best meet their needs can contact the Illinois Senior Health Insurance Program (SHIP) at (800) 252-8966 or visit <https://ilaging.illinois.gov/ship>. SHIP provides free and unbiased health insurance counseling for people with Medicare and their caregivers.

Resources

Medicare Before Age 65

<https://www.medicare.gov/basics/get-started-with-medicare/before-65>

Extra Help Program – Help with Medicare Part D costs

<https://www.medicare.gov/basics/costs/help/drug-costs>

Medicare Plan Finder tool

www.Medicare.gov

Avisery Educational Resources (includes resources for MSP, AABD Medicaid, MA, and Medicare enrollment periods)

<https://www.ageoptions.org/resources/avisery/avisery-educational-resources/>

Center for Medicare Advocacy – Medicare for People Under 65

<https://medicareadvocacy.org/under-65-project/>

Illinois Senior Health Insurance Program (SHIP)

<https://ilaging.illinois.gov/ship.html>

ⁱ H.R. 1 includes provisions that restricts Medicare eligibility for certain non-citizens. For more information, visit <https://justiceinaging.org/understanding-the-impact-of-h-r-1-on-older-immigrants-access-to-health-care>.